



VIOLENCE INCIDENT REPORT
ND DEPARTMENT OF HUMAN SERVICES
LEGAL ADVISORY UNIT
SFN 794 (Rev. 11-2002)

1. Date:		2. Specific Location: (Sketch Map on Back)	
Day of Week:			
Time:			
Assailant: <input type="checkbox"/> Female <input type="checkbox"/> Male			
3. Violence Directed Towards: Assailant Was:		<input type="checkbox"/> Patient <input type="checkbox"/> Staff	<input type="checkbox"/> Visitor <input type="checkbox"/> Other <input type="checkbox"/> Patient <input type="checkbox"/> Staff <input type="checkbox"/> Visitor <input type="checkbox"/> Other
Assailant's Name:		Assailant Was: <input type="checkbox"/> Unarmed <input type="checkbox"/> Armed (Weapon) _____	
4. Predisposing Factors: <input type="checkbox"/> Intoxication <input type="checkbox"/> Grief Reaction <input type="checkbox"/> Gang Related <input type="checkbox"/> Dissatisfied with Care/Waiting Time <input type="checkbox"/> Prior History of Violence <input type="checkbox"/> Other (Describe) _____			
5. Description of Incident: <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Verbal Abuse <input type="checkbox"/> Threat <input type="checkbox"/> Other			
6. Injuries: <input type="checkbox"/> Yes <input type="checkbox"/> No		7. Extent of Injuries:	
8. Detailed Description of Incident Including Specific Language/Behavior:			
9. Did any Person Leave the Area Because of Incident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to Determine			
10. Present at Time of Incident:		11. Needed to Call: <input type="checkbox"/> Police <input type="checkbox"/> Ambulance <input type="checkbox"/> Local Risk Manager <input type="checkbox"/> DHS Risk Manager <input type="checkbox"/> Executive Director/Superintendent	
12. Termination of Incident: Incident Diffused <input type="checkbox"/> Yes <input type="checkbox"/> No Police Notified <input type="checkbox"/> Yes <input type="checkbox"/> No Assailant Arrested <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Disposition of Assailant: <input type="checkbox"/> Stayed on Premises <input type="checkbox"/> Escorted off Premises <input type="checkbox"/> Left on Own <input type="checkbox"/> Other _____		14. Restraints Used: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____	

15. Report Completed By:

Name:	Title:
Witnesses: (Names)	
Supervisor Notified: (Name)	Time:

Please Put Additional Comments, According to Numbered Section, on Reverse Side of This Form.
Fax Completed Form to DHS Risk Manager at 328-2173.